

Integrating palliative care and hospice services in long term care: an eightfold path health policy analysis

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ABSTRACT

It is evident in the literature that as near end of life approaches, health expenditure increases. The re-hospitalization and underutilization of palliative and hospice services add to the burgeoning health cost. There is a lack of support for patients with advanced illness in long-term care facilities. This paper aims to provide a comprehensive review of the problem and assess alternatives to reduce readmission among patients with advanced disease and those who are at the end of life. This paper adapted Bardach's Eightfold Path analysis as a guide to analyzing the problem using a case study approach. The article discussed the issues, reviewed the literature for evidence, provided the alternatives, identified criteria, evaluated projected outcomes, discussed the trade-offs of adopting the policy, and provided a recommendation. In conclusion, integration of palliative and hospice care services across the continuum of long-term care is a viable alternative policy to address the problem.

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1. INTRODUCTION

According to Healthy People 2020, an estimated 50 million individuals are 65 years old and above in 2014. Sixty percent of those have one or more chronic diseases such as heart disease, cancer, chronic obstructive pulmonary disease (COPD), stroke, diabetes, and Alzheimer's disease [a] With the increase in life expectancy, there is an increasing demand for long-term care services. Such services accounted for \$300 billion in health expenditures in 2010 as reported by the Centers for Medicare and Medicaid Services (CMS). [b] Long-term care facilities include skilled nursing facilities and sub-acute rehabilitation centers.

Skilled Nursing Facility Case A is a 520-bed capacity skilled nursing facility (SNF) that accepts two types of population. The chronic long-term patients who are both Medicare and Medicaid, and sub-acute patients who are primarily Medicare A beneficiaries. Sub-acute patients have an average length of stay of 30 to 100 days. The type of sub-acute patients admitted are: patients admitted requiring post-operative rehabilitation mostly orthopedics cases; patients who are acutely ill such as complex chronic heart failure and COPD cases; patients with tracheostomy and percutaneous endoscopic gastrostomy (PEG) tube; patients requiring 1-3 months intravenous (IV) antibiotic administrations; advanced cases of cancer patients; patients who are suffering from dementia and other psychiatric disorders; and patients requiring end-of-life care. The acuity of patient's needs has been dramatically increased in recent years. More and more complex patients are admitted requiring a high level of nursing care. Readmission issues become highly contentious between hospital and SNF because hospital gets penalized by CMS for 30-day readmission. Instead of establishing a partnership and care coordination. The SNF most often are blamed for poor care management when patients get re-admitted.

Nowadays, there is an increasing pressure in acute care settings to reduce the length of stay in hospitals. Complex medically ill patients-especially those with advanced illness and patients that need end-of-life care services-are discharged to long-term care facilities. Most often, skilled nursing facilities are not equipped to manage such complex individuals with advanced illnesses because they lack the resources and trained health care professionals to meet such demands [3-4]. Advanced illness is a condition where one or more serious condition is not responsive to treatment, the overall health conditions deteriorate, and comfort care is central to the management. As they are admitted to long-term care facilities, there is an impetus to start a conversation about advanced care planning.

However, this is not the usual case in a skilled nursing facility. There is an incongruence between the patient's goal and the goals of the interdisciplinary teams involved in the care of the patient [5]. The result of these conflicting goals is ultimately rehospitalization or worst inappropriate readmission in acute care settings. It is evident in the literature that as near end-of-life approaches, health expenditure increases. The rehospitalization and underutilization of palliative and hospice services add to the burgeoning cost [6]. There is a lack of support for patients with advanced illness in long-term care facilities [2].

For example, not all individuals with advanced illness are eligible to receive hospice services. There is a fragmented payment system and reimbursement of Medicare and Medicaid [7]. The lack of support translates to fragmented care coordination, unavailability of palliative and hospice care services in long-term care facilities, lack of advanced care planning, inefficient referral to hospice hospitals, and underutilization of palliative care services in long-term care facilities. Addressing this problem is essential to improve the quality of life of patients with advanced illnesses and elderly that need end-of-life care services, as well as enhancing the the quality of care services and reducing cost and health expenditures. This paper aims to provide a comprehensive review of the problem and assess alternatives to reduce readmission among patients with advanced illness and end-of-life care.

2. RESEARCH METHOD

This policy analysis is guided by Bardach's Eightfold Path to analyze a policy issue. The eight steps in the review include: (a) define the problem. (b) assemble some evidence. (c) construct the alternatives. (d) select the criteria. (e) project the outcomes. (f) confront the trade-offs. (g) decide. (h) tell the story.

3. RESULTS AND DISCUSSIONS

3.1. Problem statement

According to the recent survey of hospitalization metrics of skilled nursing facility case a, the facility has an average of 20% 30-day readmission rate for all patients-chronic long-term and sub-acute-for the year 2018. A 30-day readmission rate provides the percent of admissions from an acute care hospital that were readmitted within 30 days. It is calculated by dividing the number of transfers to the hospital by the number of admissions from the hospital [2]. The national average according to the CMS in a report on skilled nursing facilities is at 18% [2]. The facility is close to the national benchmark average. However, the chronic long-term care residents have an average of 26% readmission rate with the highest noted at 38% in one month. This is strikingly high and above the national average rate of readmission for skilled nursing facilities. A look at the common reasons for facility transfers is the following: shortness of breath, heart failure exacerbation, pneumonia, respiratory arrest, uncontrolled pain, abnormal hemoglobin level, fever, dehydration, skin wound or ulcer, and uncontrolled hypertension. Surprisingly, these reasons are nursing-sensitive problems that can be addressed when proper medical and nursing care protocol is in place in the skilled nursing facility.

3.2. Summary of evidence

It is evident in the literature that rehospitalization is expensive. It is imperative that we look for a solution to address the issue. It is essential to know the nature and extent of the problem of rehospitalization or readmission. A survey in Veterans Administration (VA) hospitals reported that heart attack, heart failure, and pneumonia are the most common causes of patients being readmitted within 30 days of hospital discharge [8]. In another survey conducted by the Agency for Healthcare Research and Quality (AHRQ) in 2013 showed similar findings. The top five diseases were congestive heart failure, schizophrenia, and other psychotic disorders, respiratory failure, diabetes mellitus with complications and acute renal failure [9]. Strikingly, there were about 500,000 readmissions totaling \$7 billion in hospital costs in the survey [9].

The findings were consistent in skilled nursing facilities which rank heart failure as the most common diagnosis for sending the patient back to the hospital with an average of 7 days readmission [10]. In a literature review on the readmission rates among adults with cancer, bladder, pancreatic, ovarian, or liver

cancer was the highest diagnosis reported [11]. The reasons were gastrointestinal and surgical complications, infection, and dehydration. The study further emphasize that these reasons are nursing-sensitive problems that can be addressed when proper nursing care protocol is in place among cancer patients. This is reflective that SNF is not able to manage complex patients with advanced illnesses such as heart failure and cancer patients.

Care for patients with advanced illness and end-of-life care can be costly and burdensome to an individual. Therefore, it is essential that an individual enrolls in long-term care insurance since Medicare doesn't cover such "custodial care." Members of long-term care benefits had significantly reduced health care expenditures [12]. As a result, Medicaid often have the burden of taking care of this individual with advanced illness and elderly at the end-of-life care (such as in a long-term care hospital, skilled nursing facility or hospice care, which the government health programs to pay for). With increasing expenditures and cuts in funds in the agencies, it is imperative for policymakers to reduce the cost associated with readmissions, unnecessary and inappropriate admissions of patients with advanced illness.

Medicare and Medicaid are the primary agencies that regulate policies associated with long-term care services. For instance, Colaberdino et al. assessed the economic impact of an advanced illness consultation program within a Medicare Advantage plan population. They found that recipients had significantly lower spending in their end-of-life care needs as compared to non-recipients [13]. In the fiscal year 2018, CMS has an annual budget of \$738 billion. CMS is committed to driving health care costs down through policies that will build a patient-centered system of care that increases competition, quality, and access. CMS further supports innovative approaches to improve quality, accessibility, and affordability [14]. Integrating palliative care in long-term care services in addressing advanced illness and end-of-life care is in line with the goals of CMS.

Various legislation has been passed to improve the delivery of care for patients with advanced illness. For instance, the Palliative Care and Hospice Education and Training Act, Compassionate Care Act, Care Planning Act, Medicare Choices Empowerment and Protection Act, Personalize Your Care Act, Independence at Home Act, The Creating High-Quality Results and Outcomes Necessary to Improve (CHRONIC) Care Act of 2016. These measures have helped advance and improve care to a patient receiving long-term care services with chronic and advanced illness and patients at their end of life [15]. Although the passage of legislation is essential, the implementation of the law is also of equal importance. Studies and pilot projects have been conducted on how the incorporation of palliative and hospice services significantly reduced the hospital cost. In a review about the effect of palliative care consultation on hospital cost, findings showed an estimated \$250 million annually in reduced in-hospital cost among Medicaid beneficiaries. Patients who have advanced illness spend less time in intensive care and are more likely to get referrals to palliative and hospice care institutions [16].

With regards to Medicare beneficiaries, Obermeyer et al. have found that Medicare recipients with an advanced illness like cancer who receive hospice care package had a decrease in re-hospitalization. The package had an impact in decreasing use of intensive care unit and invasive procedures at the end of life [17-18]. This decrease translates to lowering hospital costs and the distribution of resources to other patients that would likely benefit from the services. The impact of integrating palliative services in terms of cost extends beyond the hospital to the community settings such as long-term care. Baxter, Rochon, and Lally argued that patients with advanced illness had a poor transition of care from the hospital to long-term care. This poorly transitioned care results in readmission or rehospitalization because patient goals and plan of care have not been communicated clearly. A pilot project that highlights the collaboration between the hospital's palliative care and the community care palliative services have shown a drop in the readmission rates of patients from 26% to 10% [19]. In addition, a partnership with high-performing skilled nursing facilities helps mitigate the risk of patients re-hospitalized [10, 20]. It is important to acknowledge the contribution of SNF in reducing the burden of hospital costs. Finally, there is a need for a policy that will integrate palliative care services across the continuum from acute care hospital to long-term care facilities [21].

3.3. The alternatives

This section discusses the policy options, alternative courses of action, and strategies or intervention to resolve the problem of fragmented care services of patients with advanced illness and patients with end-of-life care needs. *Alternative 1: Status Quo.* Designing alternatives do not necessarily always employ an intervention to address the problem. Sometimes, maintaining the status quo is itself an alternative that may be the best option for solving the issue [22]. Maintaining the status quo means that SNF Case A will continue the current services that they are providing. The palliative care needs of the patients and symptom management are at the discretion of the primary care provider who oversees the unit. There is no specialized training necessary for all the staff to meet the individual needs of patients with advanced illness. The patients

received general care as with other patients. Certified nursing assistants provide custodial care. Licensed practical nurses administer medication and treatments. Registered nurses are in charge of the assessment, care planning and evaluation of care. When patients are acutely sick, they are sent to an acute care hospital for further treatment and management.

Alternative 2: Integrating Palliative and Hospice Care Services in Long-Term Care. In this option, a palliative care team will be established in the SNF Case A as part of the team to address the needs of patients with advanced illness like heart failure, advanced cancers or patients requiring end-of-life care. The palliative team is led by a medical doctor or nurse practitioner who specializes in palliative and hospice care. The nurses and nursing assistant across different level are trained on their role in meeting the needs of patients with advanced illness. The registered nurses collaborate with the social worker in performing advanced care planning as part of the palliative services. A unit or floor may be designated to cohort patients that require palliative and hospice care services. The palliative care team will participate in the utilization review and quality improvement initiatives of the facility to improve the services and to review readmission cases. The Mary Manning Walsh Nursing Home located in the Upper East Side, New York has the same policy having a 10-unit bed dedicated to patients with palliative and hospice needs for their long-term patients. They also established collaboration and partnership with Calvary Hospital in providing palliative care consultations.

Alternative 3: Referral to Palliative and Hospice Hospitals. Another course of action to address the issue of readmission in acute care hospitals is to establish a referral system from either hospital or long-term care facilities to transfer the resident to palliative and hospital centers. In New York City a good example is the Calvary Hospital, a specialty unit hospital that offers palliative and hospice care services. In this choice, the primary care provider, nursing, and social worker collaborate to screen the resident if they are admissible and meet the criteria for palliative and hospice care [23]. One of the requirements is ensuring residents have the appropriate insurance coverage to get the services once a determination is confirmed. The staff will coordinate the transfer of the resident from the long-term care facility to the hospital.

3.4. Criteria selection

According to Bardach, there are two criteria commonly used in analyzing policy namely evaluative and practical criteria [18]. In this paper cost efficiency, equity, and feasibility is examined. *Criterion 1: Cost Efficiency.* It is imperative that the value of the project regarding cost, benefits, and savings be taken into consideration when evaluating alternatives. Do the costs outweigh the benefits of the projected outcome of the option? In this instance, creating a unique service team requires human and capital resources. Human resources are the palliative care provider like the medical doctor or nurse practitioner. Training of staff such as nurses, social worker, and therapist costs are taken into consideration. Equipment and building renovations are expenses that must be considered.

Furthermore, the benefits of this project must also be accounted for example reduction in the hospital readmission that translates to bed occupancy which equates to profitability. Admission of patients with insurance benefits that pay for palliative and hospice services will drive revenue in the facility. All of the pros and cons must be examined. A high rating of this criteria means that total benefits exceed the cost. A low score means the project has a poor return on investment.

Criterion 2: Equity. It is essential to consider the impact of the alternatives on the consumers-in this case, the patients with advanced illness and patients needing end-of-life care. Everyone deserves the right to receive care that ensures their dignity even at the end of the period of dying. The passing of Federal legislation toward self-determination and responsibility acts cemented the need ensure that each alternative of the policy provide that all recipients will have equal access to services such as palliative and hospice care [16]. A high rating of this criteria means the alternative allows equal access to all recipients and a low score perpetrates health disparities.

Criterion 3: Feasibility. The success of the project depends on the support of the leadership and management of the SNF Case A and the acceptance of patients of the services. Much weight is placed on the management side because they determine the funding for the project. Patient satisfaction and quality of care indicators will likely influence the decision-making process when evaluating the alternatives. A high rating of this criteria means that there will be more support from the stakeholders involved. Meanwhile, a low score indicates it is difficult to gain consensus and support.

3.5. Projected outcomes

Projecting the outcome involves confronting psychological difficulties associated with the policy [22]. Challenges stem from the uncertainty of the future. This paper considers the magnitude estimates and sensitivity analysis of the policy alternatives. *Magnitude Estimates.* When projecting outcome, it is essential to consider the degree the policy can have an impact on society. End-of-life care and dying with

dignity have arisen from the belief that an individual has the autonomy to decide on the care they will receive. It is not the health institution or the health care provider to determine. Integrating palliative and hospice care services directly in long-term care services will likely impact the quality of life and the type of care patients with advanced illness receive. As people live longer and live with chronic illness, this policy will have an enormous impact on the number of elderlies entering long-term care.

The economic impact of this policy should not be underestimated. Literature has firmly pointed out the role of palliative and hospice care in reducing the cost associated with invasive procedures and unnecessary hospitalization. We are talking about 500,000 readmissions totaling \$7 billion in hospital costs in the VA hospitals alone that will be saved [8]. Imagine the total hospital costs if we combined both private and public hospitals that receive funding from Medicare and Medicaid. On the other hand, the SNF Case A will significantly benefit from this policy by driving the income revenue of the facility because of the Medicare and Medicaid reimbursement scheme. Reimbursement can range from \$12,000 to \$25,000 per patients on top of the long-term care payments they receive [2]. *Alternative 2* is a win-win alternative for reducing hospital costs, increasing revenue of SNF, and improving the quality of life of patients with advanced illness and end-of-life care. Table 1 shows the outcomes matrix of evaluative criteria of the policy alternatives

Table 1. Outcomes matrix of evaluative criteria of the policy alternatives

Policy Alternatives and Criteria	Cost Efficiency	Equity	Feasibility
Alternative 1: Status Quo	Loss of revenue from empty beds related to readmission Perpetrates hospital costs	Needs of advanced illness patients and end of life care are not met. Disproportionate impact.	Not applicable
Alternative 2: Integrating Palliative care in LTC	Reduces readmission Increase profitability and revenue Decrease hospital costs Increase savings on Medicare and Medicaid	Equitable patients needs are met Improves QOL Increase in Quality care measures Continuity of care	Funding Time Frame Political support from administration Patients acceptability Availability of providers Training Funding Time frame
Alternative 3: Establishing a referral system to specialty hospitals	Increase in cost of setting transportation Increase in waiting time Limited specialty hospitals	Not equitable because of the delay in care. Not patient-centered Decrease QOL because of the breakdown in continuity of care Issues in transition	Political support from administration Coordination Patient acceptability

Sensitivity Analysis. It is suggested asking the question of how big a mistake can we afford the policy of integrating palliative and hospice care services in long-term care before this analysis becomes a big problem [18]. The smaller the affordable mistake, the more sensitive the analysis about the assumption. In this policy, we assume that integrating the palliative and hospice services would reduce readmission, increase profitability and improve the quality of life of patients with advanced illness. To offset the chances of significant errors that will be associated with the project, it is important to look at the literature. As previously reported in the literature review, both small and significant scale studies have reported a reduction in the hospital readmission which translates to cost reduction in Medicare and Medicaid spending [12, 16-19]. Furthermore, MacPherson and Parikh reported an improvement in the care of a patient receiving long-term care services with chronic and advanced illness and patients at their end of life when laws on palliative and hospice care was implemented [15]. The assumption that it will drive an increase in profitability is based on intuition. There is a need to investigate this assumption further once this policy has been in place in long-term care. It is safe to conclude that there is a low risk that the assumption is rejected. *Outcomes Matrix*, an outcome matrix organizes the policy alternatives in relation to the evaluative criteria to provide a clear picture of the projected outcome is presented in Table 1.

3.6. Confront the trade-offs

A trade-off is a decision-making process that involves considering the situation where one gives up something in return for something else. In confronting potential compromises, it is essential to find policy alternatives and their projected outcome in the evaluative criterion that was selected [18]. The evaluative criteria that were selected include cost efficiency, equity, and feasibility. Each of the alternatives will integrate the discussion of the requirements previously laden.

Alternative 1: Status Quo. Continuing the status of the SNF Case A will likely drive the readmission rate. It will probably increase the cost of emergency department utilization and re-hospitalization. Also, when patients are re-admitted to the hospital, the skilled nursing facility loses an average gross income of

\$1,500 per patient daily—and a lot of revenue due to more empty beds. On the other hand, unnecessary and inappropriate transfer of patients from an SNF to the hospital will impact patient satisfaction and quality of care. Instead of receiving comfort measures patients are subjected to unnecessary treatments and advanced procedures that affect their quality of life.

Alternative 2: Integrating Palliative and Hospice Care Services in Long-Term Care. Decreased cost of emergency visits and utilization of intensive care among patients with advanced illness and end-of-life care is one of the projected outcomes of this alternative. The cost can be distributed to another patient who would likely benefit from those services. It will hopefully decrease the congestion of patients in the emergency department [24]. In the SNF Case A, having beds occupied means income. Additionally, when specialty units are in place in the facility, it will drive more revenue by attracting patients with the insurance coverage to receive palliative and hospice care services. On the patient side, having palliative and hospice care services within the boundary of the facility will avoid the unnecessary and cumbersome transition of patients with end-of-life care and advanced illness to specialty hospitals. This service will convert to increase customer satisfaction, improve the quality of care among the elderly and patients with advanced illness. This alternative offers a win-win benefit for the owner of the facility and the patient [25].

Alternative 3: Referral to Palliative and Hospice Hospitals. Establishing a referral system to another specialty hospital like Calvary Hospital is another alternative when integrating palliative and hospice care in the facility is not possible. However, the cost of facilitating the transfer and coordination is expensive. The use of an ambulance, the driver and the escort are some examples of the expenses associated with this transfer. The literature reports that patients' level of distress increase during the transition of care [19]. The amount of effort patients' needs to consider during the adjustment period in their stay in the facility is often high. Transitioning to another facility adds to this burden instead of focusing on having quality time and preparing themselves for their end-of-life process.

Patients and family are burdened with coordinating the transfer and the paperwork needed. Communication of the patients care plan and goals are often lost during the transition of care. It will lead to further fragmented care services [19]. Referring patients to specialty hospitals will increase utilization of palliative and hospice hospitals. It means that more hospitals are needed to be built to have the services which are costly and redundant. Another critical problem of this alternative is the limited number of these hospitals in New York City. The process of assessing whether patients qualify for the services is long and tedious. Patients are often in a long queue waiting to be admitted. Delaying the deliberation of care is almost equally reflective of denying responsibility for individuals. This would be unfair for the patients.

4. CONCLUSION

4.1. Recommendation

Based on this policy analysis, the recommended alternative for addressing the need of patients with advanced illness and end-of-life care is *Alternative 2* which is integrating palliative and hospice care services in the long-term care. *Alternative 1* is not a viable option because there is an increasing call from CMS to reduce readmissions, decrease hospital costs and improve quality of life of patients with advanced illness. *Alternative 3* seems to be a viable option. However, the limited number of specialty hospitals, delays in referrals, the bureaucratic process of admission and intake of patients and the backlog of getting an empty bed are challenges posed by adopting *Alternative 3*.

Alternative 2 address the challenges by ensuring accessibility within the facility which minimizes the hassle of transferring from facility to facility and provides continuity of care. Patients and family can focus on meeting the psychosocial needs of a dying patient. *Alternative 2* have been associated with reducing cost, readmission, and improving the quality of life. The primary challenge for adopting *Alternative 2* is funding and support from SNF Case A administrator to take and implement the project. Clearly as discussed taking *Alternative 2* poses a win-win solution for all stakeholders involved. Considering all this, integrating the palliative and hospice care services within the long-term care facility is the best option based on the analysis.

4.2. Tell the story

This paper discussed the unmet needs of patients with advanced illness and end-of-life care. Readmission, inappropriate referral, and transfers from facility to facility remained a challenge within this group. Long-term care facilities lack the resources, training, and support to provide palliative and hospice care services. Laws have been enacted to address the needs of patients with advanced illness and end-of-life care. CMS further calls for initiatives that will improve quality of care and reduce hospital costs. The fragmented services of the hospital and long-term care facilities must be addressed. In conclusion,

integration of palliative and hospice care across the continuum is the viable alternative policy to solve the problem.

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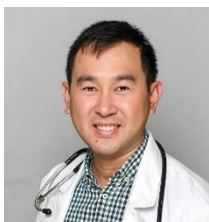
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